IN THE CIRCUIT COURT OF THE STATE OF OREGON

FOR THE COUNTY OF MULTNOMAH

THE ESTATE OF MICHELLE SCHWARZ, deceased, by and through her Personal Representative, RICHARD SCHWARZ,	)	
Plaintiff,	)	Circuit Court
	)	Case No. 0002-01376
vs.	)	
PHILIP MORRIS INCORPORATED, a foreign corporation, and ROTHS I.G.A. FOODLINER, INCORPORATED, an Oregon corporation,	)	Appellate Case
	)	No. A118589
Defendant.	)	

TRANSCRIPT OF PROCEEDINGS

Volume 25-C

3:00 p.m. - 5:05 p.m.

BE IT REMEMBERED, That the above-entitled matter came on regularly for Jury Trial and was heard before the Honorable Roosevelt Robinson, Judge of the Circuit Court of the County of Multnomah, State of Oregon, commencing at 3:00 p.m., Tuesday, February 12, 2002.

* * *

Katie Bradford, CSR 90-0148
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APPEARANCES:

Mr. D. Lawrence Wobbrock, Attorney at Law,
Mr. Charles S. Tauman, Attorney at Law,
Mr. Richard A. Lane, Attorney at Law,
Appearing on behalf of the Plaintiff;

Mr. James L. Dumas, Attorney at Law,
Mr. John W. Phillips, Attorney at Law,
Appearing on behalf of Defendant
Philip Morris, Incorporated and Defendant
Roths I.G.A. Foodliner, Incorporated.

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(Tuesday, February 12, 2002, 3:00 p.m.)

P R O C E E D I N G S

(Court Reporter Estelle Keating reported Volume 25-B.)

(Whereupon, the following proceedings were held in open court:)

THE COURT: The Court is ready to resume. I need to make my decision.

MR. WOBBROCK: We're ready, Your Honor.

THE COURT: All right. Are we back on the record?

The Court, in a sense, after just reading again the punitive damages section, 30.925(b), and listening to the argument of the parties, the Court just lost its Solomon-like flow and will not be ruling similar to Solomon.

The Court is going to make a ruling that the document in question Exhibit No. 353, although a prejudicial document, the Court is going to rule that its probative value outrules its prejudicial effect, and it will be admitted as it goes to the duration of misconduct, and also is going to allow the jurors to a comparison, when we get to comparative negligence, of Michelle Schwarz and Philip Morris.

If one of the parties wishes the Court to give a limiting instruction later on, I will, in the sense that what we're doing here, we're not emphasizing underaged smoking. Counsel?

MR. WOBBROCK: Yes, Your Honor.

THE COURT: We're not emphasizing underage smoking. The criteria that the Court just -- that the Court just indicated, as long as it's used for those purposes, the duration of the conduct for the comparative negligence, but not -- because the Court allowed youth smoking, but not underage smoking. And it would be beyond the line to get into the area of emphasizing underage smoking. That's not the emphasis and that's not a part of the case.

I have to take five minutes and take a phone call, and then we'll come back and get the jury.

MR. WOBBROCK: Your Honor, I assume your ruling would apply to the other exhibits that we showed in our offer of proof?

THE COURT: That is correct.

(Recess taken.)

MR. PHILLIPS: Your Honor, may I briefly address the Court on the issue you just ruled on?

THE COURT: You certainly may, counsel.

Proceed, please.

MR. PHILLIPS: May I have a continuing objection on this issue of this Court's decision to allow the youth smoking documents to come in the record?

THE COURT: So ordered, counsel. You may have a continuing objection.

MR. PHILLIPS: I don't know whether it's going to help, but I guess I just don't fully understand what you meant when you said, and I'll read it to you, Your Honor. "We're not emphasizing underage smoking."

THE COURT: That's correct.

MR. PHILLIPS: "The criteria that the Court just -- that the Court just indicated, as long as it's used for those purposes, the duration of the conduct for the comparative negligence, but not -- because the Court allowed youth smoking, but not underage smoking. And it would be beyond the line to get into the area" --

You are allowing them to get into underage smoking; is that right?

THE COURT: Well, as it relates to the youth smoking Marlboro, and the duration of Philip Morris' conduct in this area, and for purposes of

comparative negligence. But underage smoking itself is not an issue in the case.

MR. PHILLIPS: And you'll give an instruction on that at the end of the case?

THE COURT: Right. It's one of those hot button items, I am saying to plaintiff's counsel that is not what you are to do with this information, emphasize the underage aspect of this information. But for the purposes that the Court said you could use it for, you can use it for those purposes.

MR. PHILLIPS: Okay. With respect, I don't think a jury knows how to make that kind of analytical distinction, Your Honor.

THE COURT: I understand, counsel. That's why I said I would be willing to give a limiting instruction to that extent later on, if requested. And I have lots of confidence in juries. Sometimes they figure things out better than we expect.

MR. WOBBROCK: And I have so instructed the witness consistent with the Court's ruling, Your Honor.

THE COURT: All right. Get the jury for us as soon as you can.

MR. WOBBROCK: Your Honor, we will

probably go to the end of the day now?
THE COURT: All the way to 5:00, counsel.
(The following proceedings were held in open court, the jury being present at 3:12 p.m.:)
THE COURT: You may proceed with this witness.

DAVID BURNS

Was thereupon recalled as a witness on behalf of the Plaintiff, and, having been previously duly sworn, was examined and testified as follows:

FURTHER DIRECT EXAMINATION

BY MR. WOBBROCK:

Q Dr. Burns, I was asking you about this Exhibit 353, which Mr. Tauman is going to put up a little higher there for us. And I read the first portion of it.

"And then the incidence overall and by sex," and it shows -- you used the term "cohort," I believe and we'll hear it again. Cohorts means what?

A A cohort is a group of people, usually born within the same years, who advance forward in time.

Q Does this show an effort by Philip Morris to study different age cohorts or birth cohorts?
A Yes.
Q Could you point that out to the jury what we're talking about?
A There are two cohorts at one point in time. The survey is done at one moment in time. So someone's age then defines -- the age at the time of the survey, defines when they were born.
So they're looking at a group of people who were born during years prior to the survey when they would be 12 to 17 years old at the time of the survey. And that's a group of people, and adolescents change every couple of years, the people who are in that category, some grow out of it and others move in.
They change. You need to look at them as if they were a cohort moving forward rather than assuming that a 16 year old is the same in 1960 as they are in 1970 as they are in 1980.
Q So in light of the paragraph above that's highlighted then this shows the percentage in the birth cohort, age 12 to 17, total then male and female, of 13 percent total, or 14 percent male and 13 percent female, who they have now obtained information on that are smokers; is that correct?

A That's correct.
Q And then on the other side, it says, "Average consumption among smokers, cigarettes per day, 10.6, 12 to 17 year olds, male 12 and female 8.9; is that correct?
A That's correct.
Q Okay. Is this kind of study activity of people in this birth cohort, 12 to 17, based upon your review of the cigarette documents including Philip Morris documents, consistent with the kind of marketing practices they had towards this age group birth cohort at the time Michelle Schwarz was, say, 12 years old in 1958 until 18 years old in 1964?
A Ah, I think I understand your question, but you are confusing some of the language.
Q Okay?
A Birth cohort are individuals born during certain years, so it would only be those individuals.
Q Okay.
A However, I believe what you were asking is: Is this a demonstration that Philip Morris is interested in an age group? And that age group would also have been of interest to them earlier in time. And the answer to that is yes.
Q And what interest is this kind of data to

them? Why are they interested in the smoking habits of 12 to 17 year olds?

MR. PHILLIPS: Objection, calls for speculation -- excuse me.

THE COURT: Overruled.

Proceed, please.

THE WITNESS: Almost all new smokers, almost all the people who start smoking, do so before age 18; therefore, if you are looking to preserve the cigarette market, that is the group in which your future smokers lie.

THE COURT: What the Court would just add to the jury, the way the question was asked, is asking this doctor his opinion of why Philip Morris was doing that. We're not saying that he is stepping in Philip Morris' shoes, why Philip Morris did it, but this is his opinion why they did that.

Proceed, counsel.

BY MR. WOBBROCK:

Q Is that a learned opinion based upon your review of internal company documents of Philip Morris, and your understanding of the smoking habits and initiation habits of young people?

A Yes, it is.

Q Then I put before you Exhibit 150, and I'm

just going to read to you -- first of all, this is to Dr. Seligman. You understand he was the vice president of R & D at Philip Morris?

A Yes.

MR. WOBBROCK: If you could pull that down and show us it is a Philip Morris document, Mr. Tauman.

BY MR. WOBBROCK:

Q This is May 21st, 1975. This is, again, by Myron Johnston, who was the author of the previous document.

"The decline in the rate of the growth of Marlboro Red," a reading of Mr. Johnston's words. "It is my contention that Marlboro's phenomenal growth rate in the past has been attributable in large part to our high market penetration to younger smokers and the rapid growth in that population segment."

And then up a little bit.

"In my opinion, the decline in Marlboro's growth rate is due to four factors, the first one listed, the slower growth in the number of 15 to 19 year olds."

What does this demonstrate as to Philip Morris' interest regarding marketing to younger people or at least getting the message out to younger people

so that by the time they're 18, they decide they want to smoke?

A It demonstrates that they understood that their market was in this age group, and that they had preferentially gained cigarette users from that age group in comparison to other companies. And that as that growth in the number of adolescents in that age group slowed, the number of new Marlboro users, and the number of Marlboro sales, would also slow.

Q I'm going to read this to you. Mr. Tauman will get it in there for us.

"Marlboro smokers being on average considerably younger than the total smoking population tend to have lower than average incomes. Thus, I would expect a disproportionately large number of Marlboro smokers to quit smoking or reduce daily consumption. In addition, younger smokers are less habituated than older smokers, and, therefore, probably quit or cut down more easily than an older smoker. Furthermore, many teenagers who might otherwise have begun to smoke may have decided against it because of the adverse economic conditions."

What does this show, Dr. Burns, as to the depth of their understanding and efforts to understand factors about younger smokers?

A It demonstrates that they were quite knowledgeable, and that they were concerned that the recession which was occurring at that moment, would differentially affect the ability of adolescents and young people to start smoking because of the reduced jobs and less income that they would have. So it's a very sophisticated understanding of the influences that lead to adolescent initiation.

Q This is March 29th, 1979. Philip Morris letterhead.

"Marlboro represents 60 percent of Philip Morris USA sales," it says in the first paragraph. And then bring your attention down to, "Marlboro dominates the 17 and younger age category capturing over 50 percent of this market."

And then on the next page. "1979 special programs," by the way, for the record, this is Exhibit 190.

"Resort coverage in existence for eight years. This program represents a continuing brand presence amongst young adults. And the second point, summer sampling. Approximately 150 samplers are dispatched to beaches, shopping centers and other markets of opportunity. This program maintains a pressure on the marketplace."

The question is this, Doctor, what does this show about Philip Morris' efforts to mass market their product and surround those in an age in which they are going to make a decision about smoking with their product?

A It demonstrates a very sophisticated marketing approach. It goes beyond simply having advertising. What you do is have promotional items, T-shirts, hats, bags, coolers, all kinds of promotional items with the logo of the cigarette on it, or the name of the cigarette on it.

What that does is create the impression that everybody is using these products, that everyone is using this particular product. That creates an environment of what we call "normalization," that this is a normal, acceptable behavior, and that facilitates the uptake. We know that these marketing approaches are quite effective with young people.

Q And, finally, on this same subject, Doctor. Exhibit 211, internal memorandum of Philip Morris entitled, "Young Smokers, Prevalence, Trends Implications and Related Demographic Trends." March 31st, 1981. Again, this same fellow, Myron Johnston.

A He's been around a long time.

Q I am just going to ask you to comment on

three sentences in this document. This is under the summary. This is Page 2, I believe.

"It is important to know as much as possible about teenage smoking patterns and attitudes. Today's teenager is tomorrow's potential regular customer, an overwhelming majority of smokers first begin to smoke while still in their teens."

What does that show, Doctor, about the sophistication and their understanding about marketing to younger people and getting them to understand that by the time they're age 18, smoking isn't necessarily such an unreasonable activity?

A It shows that they knew the majority of people who start to smoke did so before 18. And in the absence of that initiation, they would not have a new generation of smokers.

Q All right. I am going to change subjects now.

A Okay.

Q You participated -- in fact, you were editor of the 1980 Surgeon General's report that I showed the jury earlier, I believe it's this red one, correct?

A That's correct.

Q And the subject of this report was what,

Doctor?
A The subject of that report was the health consequences of smoking for women.
Q And as a consequence of being an editor of this and reviewing, I take it, every writing that's in here, from multiple authors, and studies and peer reviewing them, and reviewing them yourself, and sending them out for other peer reviewers, you have a strong understanding of the health consequences of smoking for women, the subject of this report, correct?
A Yes, I do.
Q By the way, have you also participated in a recent study on the same subject?
A Yes. The 2001 Surgeon General's report was also devoted to the health consequences for women, and I was a senior reviewer and helped on that.
Q What conclusions were reached on that subject about the marketing of cigarettes to women and their concerns about cigarettes and the health consequences of that?
A Well, there are a variety of conclusions that were drawn. In 1980, the purpose of writing the report on women was that there was a perception on the part of the public that somehow women were less

susceptible to the disease consequences of smoking. And what that report showed was that the consequences for cancer and chronic lung disease were essentially identical. That while the absolute rates of heart disease in women were lower, the difference between smoking and nonsmoking women were about the same as the differences between smoking and nonsmoking men for heart disease.

And women, of course, had some special complications related to the complications of pregnancy for the mother, and complications of delivery with babies that were small and likely to be spontaneously aborted and also had a developmental delay.

And, finally, that women who used oral contraceptives were at substantially greater risk of heart disease and stroke if they smoke. So there were special consequences for women above and beyond those that were demonstrated for men.

Q Was there -- and -- we have a document that we can look at; but, also, did you discover in that '80 or the 2001 effort, there were particular concerns about women and smoking, they had certain concerns that differentiated them from men?

A There were a number of different concerns.

One of the principle ones is that women tend to be more health conscious and to use medical services; and, therefore, they are more concerned about the disease consequences of cigarette smoking.

Q And referring again to the document, this is Exhibit 075, "Market Potential of a Health Cigarette," confidential on the cover, Report No. 248. Again, Myron Johnston to Dr. Dunn.

A He does keep cropping up.

Q Conclusions -- the document is quite long and I'm just going to focus your attention on these conclusions and ask if this is consistent with what you also have learned in your research of this subject.

"As a result of the investigation summarizing this report, I have reached the following conclusions: A large portion of smokers are concerned about the relationship of cigarette smoking to health. The market share of health cigarettes increases rapidly for a brief period during each health scare and quickly stabilizes at a new and higher level of market penetration."

What does that mean?

A Well, what it means is every time we are able to effectively get a message in front of the

public that says, "Cigarette smoking is hazardous and dangerous to people," and capture people's attention to that message, people stop smoking, and the market for cigarettes drops. The number of cigarettes sold drops. That leads then to fewer and fewer people smoking.

Q And we'll talk about the cigarette company's response to that in a minute, but getting to this one which directly bears on the 1980 and 2001 Surgeon General reports that you commented on women, and particularly young women, "would constitute the greatest potential market for a health cigarette."

This is a Philip Morris document. What does it show about Philip Morris' understanding about this subject?

A They knew in 1966, that women were particularly susceptible to a message that a cigarette might deliver less damage, be safer than another cigarette. Therefore, they were a potential market for that type of marketing claim.

Q This statement here, Item 10, and these are my marks for the records, and, of course, my highlights. Again, referring to Exhibit 075, Page 3 -- 4, excuse me.

"The illusion of filtration is as

important as the fact of filtration." What's that all about?

MR. PHILLIPS: Objection, calls for speculation.

THE COURT: We'll allow him to answer if he can.

THE WITNESS: Yes. The first effort that the tobacco companies made to combat the concern that people had about cigarettes causing disease was to place a filter on the cigarette and to make claims that these filters would filter out things from the smoke.

And that left people with a firm impression that these cigarettes then delivered less smoke and were safer. In actual fact, we now know they are not any safer, they deliver the same risks. But the important point demonstrated in this memo is for purposes of marketing or selling these cigarettes, the illusion of filtration was just as important as whether or not the filters actually worked.

Q And, Doctor, the last point, Item 12, "Advertising should be directed at both sexes, but in such a way as to have a greater appeal to women."

A Yes.

Q What is the significance of that?
A That they understood that women were particularly vulnerable to a claim that said, "You can continue to smoke the safer cigarette." They are concerned more about health and if you offer them a reassurance that their cigarettes, the cigarettes they were choosing were less risky, that they would be more likely to act on that reassurance by buying and using those products.
Q Okay. Doctor, now we're going to talk about low-tar cigarettes, and we're going to connect that up with what you just said about promotion of these cigarettes to women and what promises were made. So everybody's heard about low-tar cigarettes. Do they provide less risk?
A No, unfortunately, they don't.
Q And you're going to tell us why as we go through this.
A That's correct.
Q I am going to ask you why, but we won't do it right now. Number two, do they deliver lower tar or less tar?
A Not to people.
Q Not to people. When the cigarette companies pitch their product through advertisements,

did they target women for low-tar cigarettes?
A Yes, as we've just seen.
Q Can that be demonstrated through some of their advertisements?
A It most certainly can.
Q And advertisements that are not just of Merit cigarettes, but of other products, do they influence the potential purchaser as to that type of product?
A Yes. They create an environment that describes how people view those products.
Q These are some that were showed in my opening statement.
Does this -- what's the significance of this type of ad regarding these light cigarettes in marketing to women and also a promise?
A This clearly demonstrates that people who would be concerned about the amount of tar that they were consuming and they were ingesting, are the target of this ad.
The claim is that they -- these cigarettes, this woman received 650 milligrams less tar in the last week. They are, as far as I can understand, making a promise that if you use these cigarettes, you will receive less tar. And they're

making that promise in the context of an image of women and the knowledge that women are more responsive to the health concerns about smoking.

Q And related to those issues we've been discussing, what does the significance of this type of ad show?

A This ad demonstrates who these cigarettes are marketed to. They are not marketed to the people who are continuing to smoke and don't want to stop. They are marketed to people who are concerned about quitting and are thinking about quitting, and to offer them an alternative to quitting that will keep them purchasing cigarettes.

So this is the target, a woman who is worried about her health, and who is thinking about quitting, is the target for these low-tar brands of cigarettes.

Q Again, Doctor, significance of this type of ad regarding these marketing efforts and these promises?

A Again, it very clearly demonstrates that the people that they are attempting to reach with these ads are the people who are thinking about quitting, who might otherwise make a choice about their smoking behavior that could in actuality reduce

their risk.

Q And now looking at Merit cigarettes, and just for the record, Doctor, when we talk about low-tar cigarettes, we see down in the bottom left-hand corner, I just wanted to make the record complete, do these types of cigarettes qualify for something considered a low-tar cigarette?

A They qualify in terms of advertising for low-tar cigarettes, yes.

Q And what are the numbers that make them qualify?

A They are numbers that are measured by machine of the tar content of the cigarette. The machine simply has the cigarette inserted in them, it takes a small puff about the size of two tablespoons. It takes one puff on a cigarette of that size, takes the puff over two seconds, then doesn't do anything for the rest of the minute. Then takes another puff, one puff every minute, until the cigarette burns down to 3 millimeters from the end of the filter.

Then they collect all of the particles that come through, and they remove the water and the nicotine and weigh it. And that's how they generate the number there that is the tar number. Unfortunately, you can't read it very well, but that

is how the number is generated.
Q We're going to talk a little bit more about the FTC method and some of the terms involved regarding the issues of compensation and filtration. But right now, focusing on this ad, does this ad, again, make a promise and market towards a certain individual?
A Yes. It does two things: It attracts those people who are in a dilemma about their smoking, who are concerned about their health. And, secondly, it offers them less tar. It says, "If you use our product, our product will give you less tar." That turns out not to be true.
Q And we'll talk about that in a minute.
And this final ad of Merits, and it refers to here as, "A leading light cigarette." And, again, for the record, because we are making a record with our hardworking court reporter, low tar and light cigarettes, do they mean the same thing generally in the vernacular?
A Well, in most people's understanding, they mean the same thing. People believe that a light tar cigarette delivers less tar. I don't think that that's an unreasonable belief based on the advertising that has been conducted, but it does turn out not to

be true when those cigarettes are actually used.
Q We'll talk about the truth here in a minute.
Is it your understanding that light here is used like light beer and light butter?
A Yes. It means less of those things that you don't want. I drink diet sodas and eat light foods on occasion. I am trying to avoid the calories that are present. It is an offer to deliver less of what you are concerned about: Less fat, less calories, less caffeine.
Q So the marketing of these cigarettes, Dr. Burns, to summarize, were they a response to something, and, if so, what?
A Yes. Filters and then subsequently low-tar cigarettes were a response to the concern generated in smokers by the information the public health community was generating that smoking was hazardous. It creates in the smokers a concern that something bad might happen to them. Many of them tried to quit. Most of the folks who tried to quit weren't successful. Over time through multiple quit attempts, about half the population became nonsmokers.
But that same group was then offered an alternative, in an effort to keep them purchasing

cigarettes in order to maintain them in the marketplace. That alternative was a cigarette that was filtered, would filter out what was bad, or that was light, had less of what was bad.

Q Doctor, have you not only studied this as part of your other work, but also participated in something called, "NCI Monograph 13, Risks Associated with Smoking Cigarettes with Low Machine-Measured Yields of Tar and Nicotine"?

A Yes.

Q What was your role in producing this document?

A I was an author of two of the chapters, and I was one of two editors for that volume for the National Cancer Institute.

Q And you've already told us what the National Cancer Institute is. But this monograph being number 13, is it the 13th in a series?

A Yes.

Q And let me just read you some of the titles --

MR. PHILLIPS: Objection, Your Honor. This document is not in evidence. There is a motion on it and the document has been withdrawn subject to further argument. They never returned to this

issue.
MR. WOBBROCK: I'm going to lay the foundation, Your Honor, and then we'll deal with that aspect later, if I might.
THE COURT: All right.
MR. WOBBROCK: Thank you.
BY MR. WOBBROCK:
Q Is this document produced pursuant to a government sponsored program and mandate?
A Yes. It is one of the series of National Cancer Institute monographs, and this one in particular was produced as a result of a request from the Federal Trade Commission, from the Food & Drug Administration, and the National Cancer Institute, to define the science on whether or not low-tar cigarettes did or did not reduce risk.
Q So it's an official government document.
A Yes. It is the official position of the National Cancer Institute.
Q Were there an opportunity of others to review and analyze the data therein and verify it?
A Yes. There were multiple levels of review of this document, and both at the chapter level, and the entire document level, and there was an extensive review within the agency of the National Cancer

Institute itself.
Q That's that peer review process that you have explained to us already?
A Yes, it is.
Q And what is the importance of this document to the National Cancer Institute?
A It defines the science and the status of our understanding of whether or not there are disease risks that can be reduced by changing the cigarette type that you smoke.
Q And is the information contained herein reasonably relied upon by others in your field and in the field of medicine?
A Yes. It would be extensively relied on and already has been.
Q And is this document the final word on this subject on this issue at the time it was published by the National Cancer Institute?
A Yes, it is.
Q And, again, it is one of 13 monographs and is there now a 14th?
A There is now a 14th of adolescent smoking.
Q That was published in November of last year?
A That's correct.

Q About four months old?
A That's right.
Q Okay. Doctor, now we're going to focus on some issues relating to low-tar cigarettes. And I'm going to bring this hopefully to a close before five o'clock.
A God bless you.
Q So here we go. Let's talk about some concepts. And I need to show you an exhibit, and I'm going to do this in two ways. I am going to put this up on the machine, and I'm also going to put it on a tripod. Mr. Tauman is going to pull the legs out.
While we're setting up that for people down here, can you talk about the different features of a cigarette and how they relate to the low-tar issue?
A Perhaps it might be helpful if we defined --
Q Define some terms? Okay.
A No, define where the low-tar issue came from first.
Q Okay.
A Otherwise, I think it's going to be confusing.
Q All right.

A But I'll do whatever you say. I want to get out of here by five o'clock.

Q Maybe this is overkill, but we'll put it right here.

Tell us about low-tar cigarettes and how they came to be created -- oops, I didn't do that right. I am going to set this down for a while.

A Okay. Well, as you might imagine when we found out cigarettes cause lung cancer and we found out it is really hard for people to quit, one of the things that the public health community suggested was to the tobacco companies, "Why don't you make cigarettes that deliver less tar to people? That would be a good thing to do. If people got less tar, they'd get less dose of exposure and they might get less cancer."

So that was the recommendation that led to people in the tobacco industry developing cigarettes that delivered less tar. When you deliver less tar, you also deliver less nicotine. If you deliver less nicotine, people don't get the satisfaction from the nicotine, and they don't -- they go into this withdrawal where they don't feel well without the nicotine.

If they don't get enough nicotine, they

won't continue to use the cigarette. And so the federal government, the Federal Trade Commission, adopted a measurement by which tar could be measured. It is measured by a machine. The machine takes a small puff slowly once every minute. And that is how tar is measured.

Now, there are two ways that you could approach the low-tar question: You could develop cigarettes that actually delivered less tar to people. Alternatively, you could develop a cigarette that generated a low measurement on the machine, but developed a higher dose when the person used it.

Because after all, people are addicted, but machines aren't. So if you change the cigarette to lower the dose to the machine, the machine is going to still do the same smoking behavior. If you deliver less to the person, they're going to change their smoking behavior. So there were a variety of things that were tried, and I can show you some of them.

They puffed the tobacco, so it took up more space, just like puffed wheat. They added velocity or increased ability of the paper to let air in, so the smoke -- so the tar that was burned would be more complete. They used reconstituted tobacco sheet. They take all the stems and other parts of the

tobacco, make it into paper, and take out all of the nicotine and other ingredients, make it into paper, add it back in and chop it up very finely, and put it back into the cigarette.

But the principal way the current generations of cigarettes lowered the tar delivered to a machine is here. It's by putting holes in the filter. If the machine is smoking it, you put it into the machine and it covers about this distance, just a little tiny bit of the filter, you draw slowly, and there is holes in the filter, what happens?

You get some smoke through here, but you also get air coming in through the holes. Well, the air coming in through the holes doesn't have any tar. And the machine, it doesn't take a bigger puff, so if you give it half smoke and half air, it will drop the tar measurement by 50 percent.

And you can change how much air by changing the size of those holes. But you see, smokers don't smoke to get air. They smoke to get the nicotine in the cigarette. If you don't deliver them enough nicotine, they work the cigarette harder to get the amount of nicotine and the amount of smoke that they want.

Q Is that because they're addicted, Doctor?

A It is part of the addiction. It is because they feel, they perceive the physiologic response to the nicotine as they are smoking. And if they don't get it, they pull a little harder and take a bigger puff, or they put their fingers or their lips over the holes and block it.

And then all of a sudden, the cigarette returns the amount of smoke that is being delivered to the person to the amount that that person wants. These cigarettes are designed so that they have what is called an elasticity of delivery.

That is, they will deliver a varying amount of tar and nicotine depending on how you smoke them. And, therefore, when a smoker switches from a high-tar brand that they are taking small puffs on, to a low-tar brand they say, "Gee, for the first couple of puffs, it doesn't give me what I want." So they take a little bigger puff.

They don't do it consciously often, they do is subconsciously. Take a bigger puff, draw a little harder, suck a little harder on the cigarette, and all of a sudden, the feeling is back. They have now gotten from that cigarette what they were looking for in that puff.

Q Is that what we have seen referred to in

the Philip Morris documents as the psychopharmacological response?

A Yes. Part of it is in the back of the throat. Part of it is in the brain after you absorb the nicotine in your lungs. But because smokers have a fixed dose of nicotine that they are seeking from the cigarette, and a fixed dose that they need each day that they desire to ingest each day, they simply change the way they smoke these cigarettes until they get that dose.

And when we look at people out there in the real world who are smoking cigarettes, the amount of nicotine measured in their blood, the amount of nicotine measured in their blood is the same or essentially the same for someone who is smoking a tenth of a milligram nicotine cigarette, and someone who is smoking a 1.8 milligram cigarette, almost 20 times as much measurement by machine.

So what happened was the cigarettes were designed to generate low numbers on the machine, so those low numbers could be offered to smokers as reassuring them that they're getting less risk: Less tar, less dose, less risk. When in actual fact, the same cigarettes were engineered so that when the smoker put them in their mouth, they would get a full

satisfaction, a full dose of tar and nicotine.

And we now know that that full dose of nicotine was accompanied by a full measure of risk. And the people who switched to these products in an effort to reduce their risk bought an illusion of risk reduction, not the reality, and they lost an ability to quit and really reduce their risk.

Q Let's go back over just a couple things so that we're clear here. This is a picture that Dr. Benowitz drew.

A I'll stay away from these.

Q When you talk about the machine method --

A Right.

Q -- is this what you're referring to?

A Sure. This is a simplification of that. You put the cigarette into this little piece, the little fitting that the cigarette fits into. You take a little pump, pull the pump back slowly, take a small puff, and in between those two, you put a filter.

That filter is very, very fine, and it collects all -- this is not a cigarette filter. This is a chemical filter and it picks up all of the very fine particles. You take those particles and you weigh them. And you remove the nicotine and remove the water, and what remains is all the rest of the

substances that are the particles called tar.
And so tar is really a measure of all of the smoke. If there is no tar in a cigarette, there is zero tar, there simply is no smoke to that cigarette. You would not see anything curling up from the cigarette or being exhaled or inhaled by the smoker.
Q Those nitrosamines and benzynes that big list that Dr. Wakeham had, is that in the tar?
A Most of those are contained in the tar. Most of the carcinogenic cancer-causing activity of the cigarette is contained in the tar component of the cigarette.
Q Are you, therefore, saying, Doctor, when someone actually smokes a low-tar cigarette like a Merit, they get essentially the same amount of tar as they would as if they'd smoked a regular cigarette with higher tar and nicotine measurements pursuant to this method?
A Yes. More directly, if someone switches from a high-tar cigarette to a low-tar cigarette measured by machine, from a high-tar cigarette to a Merit, they still get the same dose. They change the way they smoke the cigarette to preserve the dose of tar and the amount of risk that results from that tar.

Q Would that apply from someone who switches, for example, from a Benson & Hedges to a Merit, such as Michelle Schwarz?
A It most certainly would.
Q I'm going show you some documents again and ask you --
A Is Mr. Johnston still around?
Q No, this is Mr. Schori and Dr. Dunn, a 1971 document. I'm going to show you three -- this is Exhibit 125, three highlighted portions. And Mr. Tauman is going to put those up and ask you what they mean. That's the cover. This is the next inside cover. This is 1971. Go down to the yellow highlighted portion, and I'll read it for the record.
"As tar delivery decreased from that to which the smokers were accustomed, cigarette consumption increased. This resulted in a tendency for the smoker's daily intake of tar to remain constant even though the tar deliveries of the cigarettes he smoked differed markedly."
Tell us what that means.
A What that means is that these people were compensated. There are two ways that you can compensate: One, is by changing the way you smoke an individual cigarette; the other is by changing the

number of cigarettes that you smoke.

Compensate means that you change behavior to preserve how much nicotine you're getting from your cigarette smoke. What this shows is that when people switched from a high-tar product to a low-tar product, they compensated. And the result was they preserved constantly the amount of tar that they got, even though the two cigarettes, when measured by machine, had very different deals.

Q And then referring on, "When nicotine increased from that to which the smokers were accustomed, 1.3 milligrams, cigarette consumption decreased."

A That's right.

Q "This resulted in the tendency for smokers' daily intake of nicotine to remain constant even though the nicotine deliveries of the cigarettes you smoked differed markedly."

A Yes. This shows that compensation works in the other direction as well. If you put more nicotine into the cigarette people will smoke less.

Q "With nicotine, however, the change in consumption is not nearly as great as that observed with tar. These findings support the hypotheses that the smoker does have daily intake quotas for tar

and/or nicotine, and that he titrates his smoke intake to meet his quotas."

There is a word there that I'm not sure we use every day around here. What's titrate mean?

A Titrate means that you adjust in a very fine manner how you do something; in this case, how you smoke on an individual cigarette-by-cigarette basis.

Q And this -- does this say, Doctor, that the compensation for tar is more complete than that for nicotine? Is that what it means?

A No. It says that they were uncertain as to whether people were titrating or compensating specifically for nicotine or specifically for tar. It really doesn't make too much difference because the ratio in the smoke is constant across cigarettes. High-tar cigarettes and low-tar cigarettes have the same amount of -- same ratio of tar to nicotine.

So it is very difficult to separate whether -- in the early days, whether people were smoking in order to get tar or smoking in order to get nicotine. We now know from other work with the added nicotine to cigarettes, that it's predominantly nicotine that people are adjusting their smoking behavior for.

Q This is 1971?
A 1971.
Q And this is five years before the introduction of the Merit cigarettes; is that correct?
A That's correct.
MR. WOBBROCK: On to the next page, Mr. Tauman.
BY MR. WOBBROCK:
Q In figure three, "Cigarette units smoked is shown as a function of cigarette nicotine delivery level that can be seen from this figure. The lowest nicotine delivery resulted in the greatest consumption while the highest nicotine delivery resulted in the least consumption."
Is that compensation again, Doctor?
A Yes. What they say in the next sentence makes that clear. "If smoking behavior had not been dependent upon nicotine delivery." If you were weren't using the cigarette differently in order to get a constant amount of nicotine, then this effect would not have been present.
Q You just summarized that, "If smoking behavior had not been dependent upon nicotine delivery, cigarette units smoked would have been equal for all nicotine deliveries. This would mean that as

available nicotine increased, the smoker had a proportionally larger nicotine intake."

And I take it, the smoker did not?

A That's correct.

Q At a constant level?

A That's correct.

Q And, finally, "In terms of nicotine consumption became increasingly smaller as nicotine delivery became increasingly higher than that to which the smokers were accustomed. The result of this decrease in consumption was that the smokers daily intake of nicotine did not simply rise in proportion to the increase of available nicotine in the cigarettes he was smoking. He tended to maintain a relatively constant nicotine intake when smoking cigarettes with vastly different nicotine deliveries."

That's what we've been talking about, compensation?

A This is what we have subsequently come to understand happens in the real word of cigarette smoking, which is that it really doesn't make too much difference what the machine measurement of the cigarette is, the smoker, when they actually use them, titrates and changes the way they use the cigarette to keep the dose constant.

Q Did the public health community request that these low-tar cigarettes that are marketed today and were marketed in 1976 as Merits, be developed in the manner in which they were to deliver the kind of product that they do?

A No. They never requested that the cigarette that reduced the yield to a machine, but kept the dose of tar constant to people be developed. That was never the recommendation of the Public Health Service.

Q To summarize, Doctor, on this subject, who were these low-tar cigarettes marketed to?

A They were marketed to people who were concerned about their health, to women, to people who would otherwise have quit smoking; and, therefore, left the cigarette market, reducing in reality, their disease risk.

Q Why would they target cigarettes to people who wanted to quit?

A Because when people quit, they stopped buying cigarettes; and, therefore, there is less profit for the company.

Q What was the net public health effect of doing that?

A Net public health effect was that we have

more, not less lung cancer, than we would have had otherwise. Those people who would have quit, would not have developed lung cancer at the rates at which the people who continued to smoke did. Had they not bought into the illusion of low tar, some of those people would be alive today.

Q Are you telling this jury, Dr. Burns, that people got no benefit from these types of cigarettes and lost the opportunity to quit?

A That's exactly what I'm saying.

Q And why were women potentially the target of this type of program?

A Because women were more concerned about their health; and, therefore, more vulnerable to this type of marketing message.

Q When Philip Morris represented these cigarettes as low tar, these Merit cigarettes, was that the truth?

A No. That was an illusion that they were offering the people who used those products.

Q Was it a half-truth?

A No, it wasn't even a half-truth.

Q Was it a misrepresentation?

A It was a direct misrepresentation that they were going to get less tar from that product.

Q What would be the whole truth?
A The whole truth would be, it doesn't make any difference what cigarette you smoke. It doesn't make any difference what you call that cigarette. Whether you call it a light or ultra light, your risk is the same.
Q Let's go back to something. You participated again in the Surgeon General Report, the 1981 Surgeon General Report?
A That's correct.
Q Did that concern itself with low-tar cigarettes?
A Yes, it did.
Q Was there a conclusion in that report?
A Yes, there was.
Q And what was that conclusion?
A The conclusion was that if you can't quit, or are unwilling to try, you should switch to low-tar cigarettes.
Q And is that the current position of the Surgeon General reports, the Public Health Service, the National Cancer Institute on that subject?
A No, it is not.
Q What is the current position and what has changed?

A The current position is that it doesn't make any difference what cigarette you smoke, there is no benefit to cutting -- to changing the brand of cigarettes that you smoke to reduce the machine-measured tar. There is no reduction in disease risk.

What has changed since that time is two things: We have gained a much deeper appreciation in how much detail people change the way they smoke to preserve their ingestion of nicotine; and, secondly, we now have a much deeper understanding of how these cigarettes are engineered to produce whatever dose of nicotine and tar the person wants from the cigarette, simply by changing the way they smoke.

Q Are you aware of an internal Philip Morris document that had you been aware of it in 1981 would have changed the recommendation of the 1981 Surgeon General report?

A Yes.

Q Is that called the Barbro Goodman 1975 Marlboro, Marlboro Lights study?

A It is one of the studies done in 1975 by Barbro Goodman.

Q And is this Exhibit 153, I think for the record it is 153. I know that, perhaps you don't. Is

Exhibit 153, is this the study?
Pull that down a little bit.
A Yes, I believe this is the study.
Q Now, first of all, let's take some basic concepts here. What relevance does the study of Marlboro and Marlboro Lights have to a situation where Michelle Schwarz switched from Benson & Hedges to Merits?
A The relevance is that all low-yield cigarettes accomplish that lower yield through ventilating the filters, through poking holes in the filters so that you get air instead of smoke. So any ventilated filter delivers less tar. And the way you produce a low-tar cigarette is by putting holes in the filter predominately.
And the size of the reduction can be increased or decreased by changing the size of the hole in the filter. There is no difference in the amount of tobacco in the cigarette. There is no difference in the amount of tar -- nicotine in that tobacco. The principal difference is the size of the hole and the number of holes in that filter.
Q Now, this study is dated 1975. You were not made aware of this study at the time that you prepared the 1981 Surgeon General's Report, correct?

A Six years later we did not have access to this information or this understanding of cigarette design.
Q And the device they used called the smoking machine, was that available to the Public Health Service?
A No, it was not. And as a matter of fact, that report recommended that machines like this be developed so we could match how people's smoking behavior actually was translated into a machine measurement.
Q And when you say that report recommended that, you are referring to the 1981 Surgeon General's Report, correct?
A That's correct.
Q Now, let take a look at this report. I think we can understand it without reading the whole thing. But if you want to go outside my highlights, feel free to do that.
MR. WOBBROCK: Maybe you could back off just a little to the get the margin in there, Mr. Tauman. There we go.
BY MR. WOBBROCK:
Q "There were a total of nine smokers participating in this study which spanned a period of

four weeks. The first two weeks, they smoked their regular brand. Then switched exclusively to the alternate cigarette, Marlboro 85 or Marlboro Lights."

So does this mean they went from a regular cigarette to a light and a light to a regular cigarette?

A Yes.

Q Okay. Now, how does the smoking machine or smoker simulator that is mentioned in the first paragraph, how does that fit into all this?

A Well, as I said, the problem with the machine used by the Federal Trade Commission, it is not addicted. It doesn't change the way it smokes. And so, therefore, it pulls the same amount. What this machine does is mimic the way someone smokes.

What they do is they take and have the person smoke, inserting a little device, so that they can measure how much flow is occurring, so they can measure when someone takes a puff, how hard they pull on that puff how deep that puff is, how big it is.

Then they record that on a tape, and they use that tape then to have the machine smoke exactly the same way. So they have a machine now that will change the way it smokes the cigarette if the person changes the way they smoke a cigarette.

Q Okay. Let's go to the conclusions of this study. It's highlighted there, I think on the next page and the following page.

"The smoker data collected in this study are in agreement with results found in other projects studied. The panelists smoked the cigarettes according to physical properties. For example, the dilution and lower resistance to draw of Marlboro Lights caused the smokers to take larger puffs on that cigarette than on Marlboro 85s.

"The larger puffs, in turn, increase the delivery of Marlboro Lights proportionally. In effect, the Marlboro 85 smokers in this study did not achieve any reduction in smoke intake by smoking a cigarette, Marlboro Lights, normally considered lower in delivery. Conversely, the Marlboro Light smokers did not increase their smoke intake when they changed to the regular delivery cigarette."

Is this the compensation you have been the telling us about?

A Yes. There wasn't any difference in how much smoke people got from the Marlboro or the Marlboro Light. There isn't any difference in how much smoke they got. There wasn't going to be any difference in how much risk they got. Had we known

that in 1981, we never would have recommended that people switch to these products.

Q Now, Dr. Burns, the FTC method when that was prescribed for the industry or set out for the industry, the industry knew that people didn't necessarily smoke like a machine, didn't they?

A Absolutely, as did the Public Health Community.

Q And in the 1981 Surgeon General's Report, recommending that people switch to low-tar cigarettes without this information, they did know about the concept of compensation, correct?

A Absolutely.

Q Okay. What did this report then add to those two things? How would this have made a difference?

A We knew in 1981, that if you put holes in the filter, and that had been identified in published research a couple years previously, if you put holes in the filter, people took bigger puffs. But we thought that people were just taking the bigger puff because there was less resistance when they pulled on the cigarette.

We thought that the addiction to nicotine worked on a long-term basis, that is, maybe over a

long period of time you might try to get the nicotine. What we didn't understand was that the relationship between nicotine ingestion or the amount of nicotine you got and the cigarette, operated within the puff. That is, that the smoker would change the way they puffed on the cigarette, the intensity, the depth of that puff, the depth of inhalation, until they got enough nicotine.

And that was an immediate feedback that they were capable of receiving and adjusting their own smoking behavior to achieve. So we thought the compensation was sort of a passive phenomena that resulted from the resistance in the cigarette, what it resulted when people covered the holes with their lips.

We had no clear understanding of how detailed that compensation was and how active a role it played in defining the smoker's individual puff-by-puff smoking behavior.

Q Are you saying, Doctor, that this -- this compensation is, for lack of a better term, a subconscious way the smoker achieves the same intake of nicotine?

A In some smokers it is conscious. They recognize that they are not getting the feel that they

normally get from a cigarette, so they consciously change the way they smoke. For many smokers, however, it is a learned phenomena. They don't get as much, so they take a bigger puff. That gives them more and they feel better.

They then feed that back subconsciously to change the way they smoke. They don't do it on purpose, and by and large, they are not capable of consciously saying, "I am not going to do it," other than in an artificial way of saying, "Okay. For this puff, I am going to take a small puff," that they can do.

But when they use it on a regular basis, they can't slide down to change the way they smoke that cigarette so they get less tar and nicotine. They can't consciously or subconsciously mimic the machine on a long-term basis.

Q I am going to ask you to look at Exhibit 6 again, Doctor. This is The Frank Statement.

MR. WOBBROCK: Move that up just a little. And then we focus on the last line on the left side, Mr. Tauman.

BY MR. WOBBROCK:

Q By not sharing this information that they had in 1975, the Barbro Goodman study, Exhibit 175,

did they cooperate closely with those whose task it was to safeguard the public health?

A No, they did not.

Q And the previous document, the Barbro Goodman study, Mr. Tauman points out to me is Exhibit 153 for the record and the jury.

All right. Doctor, I am going to ask you questions about Michelle Schwarz. At my request have you looked at her medical records?

A Yes, I have.

Q Have you in the past looked at medical records of patients of your own that suffered the same type of lung cancer?

A Yes, I have.

Q And have you cared for those patients?

A Yes, I have.

Q Have you particularly focused on her records concerning her last illness that I asked you to look at?

A Yes.

Q And you are aware that she had a metastatic brain tumor?

A She had a metastatic carcinoma of the lung.

Q Meaning it spread to her brain from her

lung?
A Yes, that's correct.
Q And you're aware, Doctor, I'd just ask to you assume that she smoked Benson & Hedges, about a pack a day, from 1964 to 1976. And then she switched to Merit cigarettes, and she smoked those cigarettes up until shortly before her death, July 13th of 1999, having been diagnosed February 10th of 1998 with a metastatic brain lesion.
A Yes.
Q That her husband observed her and so did her mother taking deeper puffs, inhaling deeper and longer after she switched to the Merit cigarettes. They both testified to that happening. I ask you this based upon your understanding of medicine, your care of these kinds of patients, your diagnosis and treatment of patients with lung cancer, this being adenocarcinoma, as you know, having read the medical records.
In your opinion, Doctor, did Michelle Schwarz's cigarette smoking in the last eight years of her life with Merit cigarettes substantially contribute to her death?
A Yes, it certainly did.
Q And did it substantially contribute to her

lung cancer that caused her death?
A Yes. It caused her lung cancer and her lung cancer caused her death.
Q I'll ask Mr. Tauman to put part of the record up on the viewer.
This is Page 27, transcribed portion of defense counsel's opening statement. This is what the lawyer said on behalf of Philip Morris about five days ago in this courtroom.
MR. PHILLIPS: Your Honor, may I approach?
THE COURT: Yes, counsel.
MR. PHILLIPS: Would you take that off, please, Mr. Tauman?
(Sidebar conference between Court and counsel, off the record.)
THE COURT: Is the jury okay?
BY MR. WOBBROCK:
Q What is adenocarcinoma of the lung, Doctor?
A Adenocarcinoma of the lung is one of the four principle types of lung cancer.
Q How common is adenocarcinoma of the lung in women who smoke?
A Adenocarcinoma is now the most common form of lung cancer in women who smoke.

Q I want you to assume this fact: Assume what was said in this courtroom, that one-half of the adenocarcinoma of the lung -- excuse me.

Assume it was said in this courtroom that less than one-half of the adenocarcinoma of the lung in women is in smokers. In other words, less than half the women that get adenocarcinoma of the lung are smokers. I want you to assume that was said in this courtroom. Is that true?

A No, that's not true.

Q What is more accurate?

A More accurate numbers between 80 to 95 percent of the adenocarcinoma that occurs in women currently occurs in cigarette smokers.

MR. WOBBROCK: I believe that is all I have, Your Honor.

THE COURT: Thank you.

Cross-examination, counsel.

MR. PHILLIPS: Thank you, Your Honor. I may need a moment to shift materials.

THE COURT: Very well.

MR. WOBBROCK: I will take away my exhibits while counsel is doing that, Your Honor.

THE COURT: Very good.

(Pause in proceedings.)

MR. PHILLIPS: Let's see if I can put this up here if I can.
THE WITNESS: You're not going to make me draw now, are you?
MR. PHILLIPS: No.

CROSS-EXAMINATION

BY MR. PHILLIPS:
Q Good afternoon, Dr. Burns.
A Good afternoon.
Q Dr. Burns, you mentioned that you've testified in 24 or 25 trials, I believe, against Philip Morris or other tobacco companies; is that correct?
A I believe that's correct.
Q In fact, you testified at the end of last week in Kansas City for another plaintiff in another case against another tobacco company, correct?
A That's correct.
Q And much of what you presented to this jury today you have presented to many, many other juries; is that right?
A That's correct.
Q All right. You spend about 95 percent of

your time these days on tobacco policy matters including testifying for individual plaintiffs in cases like this one; isn't that right?

A I am not sure that is a full characterization. What I do is I spend most of my time on research on smoking behavior, measurement of risk due to smoking and tobacco control research. And then I spend some time testifying. I can't give you exactly a percentage of time, but it is 10, 15 or 20 percent, depends on the month.

Q All the work regarding tobacco control comprises about 95 percent of your schedule, right?

A That's correct.

Q All right. And you spend more time working on lawsuits like this one than you do seeing patients, right?

A At this moment in history, that's correct.

Q And while you told the jury that you testified in 23 or 24 trials, you have actually testified in depositions in many, many more cases; isn't that right?

A There are more depositions than I could count, that's correct.

Q All right. That's because, in part, you have been named as an expert witness in many, many

more cases than you've ever testified in, correct?
A I don't know that that is true. I have certainly been named in lots of cases that I knew nothing about. That is one issue. It is also true that some cases did not come to trial, I guess, but most of those depositions were involved with cases that ultimately came to trial or to resolution.
Q You mentioned something that I want to make sure that the jury understands. You have been named as an expert witness in cases against tobacco companies by lawyers who never even bothered to contact you, right?
A That's correct.
Q Plaintiffs' lawyers, right?
A I am assuming so. I don't know in detail what side they were on. I assume there were plaintiffs' lawyers.
Q And you have been testifying against tobacco companies like Philip Morris for more than 20 years now; isn't that right?
A That's right.
Q And you have been busy in particular, in the last year, you have testified in a number of trials; isn't that right?
A That's correct.

Q Okay. And you get paid $500 per hour for that work; isn't that right?
A Most of the time. Not in this trial, but most of the time.
Q Dr. Burns, you are very interested in helping plaintiffs' lawyers win individual cases, wrongful death cases like this against companies like Philip Morris, because you believe it will advance public policy, don't you?
A Well, I oscillate back and forth, quite frankly. I think that if cases are won in a way that changes the way the tobacco industry behaves, then, yes, that would be a substantial advance in public policy. If they change their advertising practices, if they change their assistance to people who are trying to quit. Those are things that I think would be substantial advances.
That hasn't happened to date. So some days, I, quite frankly, despair that it will happen; other days, I think it might be possible, so I oscillate back and forth.
Q But what you've told others and what you have said and you testified to before is that you believe it is a public policy worth pursuing, helping plaintiff's lawyers pursue these individual lawsuits,

right?
A There is an area that it's my understanding that the Court does not want us to discuss where I believe that has, indeed, had a powerful public policy impact.
Q I am talking about individual lawsuits now, sir.
A As I've said, I'm not sure that the individual lawsuits do. Some days, I feel that it may have an impact, would particularly have an impact if it led to changes in tobacco industry behavior. On other days --
Q Excuse me.
A -- the frequency with which the verdicts have favored the plaintiffs have led me to think that that may not happen.
Q All right. The fact is that you've helped plaintiffs' lawyers by participating in mock trials with them, correct?
A Yes, that's correct.
Q And you've given lectures to groups of plaintiffs' lawyers and conferences who -- those lawyers were interested in bringing lawsuits against tobacco companies like Philip Morris; isn't that right, sir?

A Yes. As I recall, I have done two mock trials and I've done two or three lectures over the last 20 years or so.

Q And you have appeared in press conferences with groups of plaintiff's lawyers who were interested in suing tobacco companies; isn't that right?

A Well, I think that is not a fair characterization. I appeared in a press conference to announce a settlement with Liggett by those attorneys, yes.

Q And you were paid to write a book to be used by asbestos companies in lawsuits against tobacco companies, isn't that also right?

A That's correct.

Q And in your own hometown or near your hometown of Del Mar, California, you supported a law that would restrict smoking on sidewalks and parts of the beach; isn't that right?

A I have supported many laws that restrict where smoking is allowed, including laws that restricted smoking in the community of Del Mar on the beach and on the sidewalks, yes. It was not a law. It was a proposition.

Q Well, you supported that proposition because you wanted to create a social environment in

which smoking is perceived negatively, right?

A No. Actually, the reason why I supported that proposition is that I thought it would focus the attention on the fact that it was the presence of the smoke, not the location in which it was received, that was the problem. And the fact that you were walking down the street behind a smoker meant that you could be exposed just as it would be if you were sitting next to them in a restaurant. So I thought that was a useful advance and communication of the risks to people.

Q Is it not your testimony that you supported that proposition to create a social environment in which cigarette smoking is perceived negatively?

A I think that in general I have supported that kind of restriction for that purpose, yes; but not that specific ordinance or that specific referendum --

Q Well, you have written before that, "The segregation of smokers in smoking sections has become a social rejection of the smoker and has established a strong social stigma to the act of smoking. Separation and the need to request permission become barriers to the sociologic utility of smoking and the

repetitive need to define one's self as a smoker by requesting a smoking section has become a persistent sociological assault on the smoker's image."

You said that, didn't you?

A I have written that, yes.

Q Just to be clear, you would like -- in your position, you would like to see smoking disappear; isn't that right?

A I am a physician. I would like never again to have anybody develop a disease related to cigarette smoking. That's where my goal comes from, yes.

Q Now, in the information that you were given about Michelle Schwarz, Dr. Burns --

A Uh-huh.

Q -- you were given no information that Michelle Schwarz was going to quit if she didn't have Merit cigarettes available to her; isn't that right?

A That's correct.

Q And you have no knowledge and you would be totally speculating to suggest that she would have quit without Merit cigarettes; isn't that right?

A It is not total speculation, it would be based on population data; but I have no specific data with relation to her, that's correct.

Q And you're aware that some people switch to lower tar or ultra low-tar cigarettes as a means of weaning them off cigarettes; isn't that right?

A I am aware that people report that that's their intent. That does not happen because they don't get a lower dose of nicotine; but that's what they thought they were doing when they switched to those cigarettes.

Q Now, I want to ask you some questions, Dr. Burns, about the '54 Frank Statement. You were shown that, correct?

A I was.

Q And it was certainly the case of the tobacco companies who signed that document were hardly alone in 1954 in believing at that time that smoking had not been proven to cause lung cancer, correct?

A I think that is a correct statement, yes; that there was, indeed, residual scientific doubt at that time.

Q And it is also the case that in 1962, when President Kennedy commissioned or ordered the Surgeon General to commission a blue ribbon panel to undertake a thorough examination of the question, that that report in 1964, was the definitive statement by the Surgeon General that smoking was associated and was

causally related to lung cancer, correct?
A Yes. I am not quite sure what your question is. It was a report to the Surgeon General. The Surgeon General certainly endorsed its conclusions at that time, yes.
Q And you've indicated that the Surgeon General's reports are the definitive statement of the Public Health Service at a particular point in time regarding, in this case, smoking and health, correct?
A At a point in time, yes.
Q And in 1964, the Surgeon General's report in 1964 was that definitive statement, correct?
A That's correct.
Q It expressed a scientific consensus, correct?
A Yes.
Q Now, you mentioned that there was some concern that perhaps there was a feeling that women weren't subject to the potential illnesses associated with smoking. Do you recall your testimony in that regard?
A I do.
Q Okay. In that respect, the Surgeon General's report in 1964, concluded that it had been established that smoking caused lung cancer in men,

correct?
A That's correct.
Q And it said because the data had not more fully developed that it was only suggestive that it was causal in women, correct?
A That's correct.
Q And the reason that the data hadn't developed is just because of the charts you showed us earlier, right? Women started smoking later than men, correct?
A That's correct.
Q Okay. And within a couple years after 1964, the Surgeon General concluded that smoking was causally associated with lung cancer in women, correct?
A It certainly did.
Q It didn't take very long after that, right?
A Right. It was within a couple years.
Q And you're not aware of any popular impression coming out of the Surgeon General's Report in 1964, that women were exempt from the conclusions regarding health risk, correct?
A Exempt, I guess, is too strong a word. I don't think people were exempt, or that women were

exempt. But certainly there was a clear impression when I was in the Public Health Service in the mid-1970s that women were somehow protected from the disease consequences, that either due to hormonal influences or other factors, they would get less lung cancer, less chronic lung disease, less heart disease from smoking cigarettes than would men. That perception was clearly present at that time, at least as I recall.

Q Okay. Let me ask you to put it this way. When the Surgeon General warnings went on the packs of cigarettes, they didn't carve out an exception for women, did they?

A No, they certainly didn't.

Q The warning was to the entire population, right?

A It was to the entire population and everyone was felt to be at risk at that point in time.

Q Now, I want to talk about CTR for a second, the Council for Tobacco Research. Because you were involved in so many Surgeon General's reports --

A Surgeon's General.

Q I will let you say that.

A I always get it backwards, too.

Q You know that, in fact, there were many,

many publications by independent scientists who were funded by the Council for Tobacco Research?

A Yes, I do.

Q And that those publications were cited repeatedly by the Surgeon General on important issues of smoking and health?

A Yes. The number that I am familiar with is somewhere around 600 cited in Surgeon General's reports over the years.

Q And those were studies funded by the tobacco industry, by Philip Morris through CTR, correct?

A That's correct.

Q And they were important to the issue of smoking and health, correct?

A They were important to issues largely on the mechanisms of the disease; but, yes, they were important to the issues of smoking.

Q Well, and some of them focused on the health risks of women, didn't they?

A Yes, they did.

Q Including the one that you mentioned earlier that women are at risk for having low birth weight babies. Much of the research that led to those conclusions and led to a warning on the package on

that subject was done by CTR-funded independent scientists, correct?

A Certainly, they funded some of that work. I am not sure that I would qualify it as much, but that is the predominate amount. But, yes, they certainly did fund work, particularly early in the years of the CTR fund.

Q Now, I want to go to this issue -- let me just ask this. In all of your discussions regarding advertising, you didn't show the jury any Benson & Hedges advertisements, did you?

A I don't recall any.

Q And you are not an expert on Benson & Hedges advertising or whether it was intended to market to kids or anything like that, correct?

A I am not testifying on that today, no.

Q Now, by the way, you also showed a whole bunch of advertisements for other tobacco companies' cigarettes, do you remember, True and Vantage and Doral. Do you recall those?

A I do.

Q You understand that none of those products are made by Philip Morris, right?

A I understand some of them are not.

Q All of those.

A I simply don't have a full recall of every cigarette brand --
Q Will you accept my representation, sir?
A I certainly will.
Q Neither Vantage or Doral or True are made by Philip Morris.
A Yes, I would be perfectly willing to accept that.
Q And will you accept my representation that Philip Morris had absolutely no control over anything that was said in any of those advertisements by other tobacco companies?
A I would agree with that.
Q All right. Now, you mentioned that your recent work in the last three or four months has reached the conclusion that low-tar cigarettes are not less hazardous; is that fair?
A Well, let me clarify things so we are all on the same page.
Q All right.
A That was work that came out last November, which is three or four months ago, so it's not work in the last several months. And it was the result of about a three-year effort.
Q All right. So the publication of it came

out in the last few months. It was an effort that built over time, fair enough?

A That's correct.

Q And that conclusion is based on, in part, review of the epidemiology, correct?

A That's correct.

Q Now, again, for the sake of the jury, epidemiology is the study of human populations, right?

A That's correct.

Q And so if you're trying to figure out if an exposure to something is either more or less hazardous, you look at the two populations that are exposed to one thing or not exposed to it and you try to see what their disease experience is over time, correct?

A Roughly, correct. That's right.

Q And you agree, do you not, that the epidemiology, those studies of human populations for the last 30 to 35 years, drew the conclusion that filtered cigarettes, those that you talked about the illusion as well as the reality of filtration, and low-tar cigarettes are less hazardous than regular cigarettes, correct?

A That is correct. If the studies compare two populations of users and control for the number of

cigarettes smoked per day, that's the result that is generated. The problem there is that if you control for the number of cigarettes per day, you don't control for the fact that the high-tar smoker of 20 cigarettes per day, when they shifted to low tar, it went to 25 cigarettes per day.

Therefore, by controlling as if those two numbers were the same, we bias the results and produce an artifact or artificial demonstration of a risk reduction that turns out not to be real.

Q Okay. But this analysis, and this is an analysis that you have done; isn't that right?

A Yes.

Q Okay. And what you've concluded is that epidemiological studies that were done in the '60s and the '70s, and which led the public health community to recommend to people like Michelle Schwarz that she should switch to a low-tar cigarette if she doesn't quit, that those studies, based on your review today, came to the wrong conclusions, right?

A No. What we did is we said those studies came to the correct conclusion. They had the wrong understanding of the way people used cigarettes and they did not understand that the compensation included a shift in number of cigarettes smoked per day.

And when the appropriate epidemiologic studies were done, comparisons of real populations of real people who smoked very different brands of cigarettes some 20 years apart, instead of declining, as one might have expected, the risks actually rose.

Q So, in other words, because those studies weren't able to take account one form of compensation, the form of smoking more cigarettes, they missed the fact that by smoking more cigarettes, any reduction of risk was eliminated; is that fair?

A I couldn't follow your question. I am sorry.

Q All right. I want the jury to understand here is what you have -- your studies has done in the last few months -- that you published in the last few months.

A Okay.

Q And as I understand it, the epidemiological studies that were done before were done by public health scientists, right, not by Philip Morris?

A Competent, good people who did this with excellent methodology.

Q Okay. Those people came to the conclusion that low tar and filtered cigarettes are safer than

regular cigarettes, correct?
A That's correct. As did we in 1981, based on some of that same evidence.
Q All right. I am going to approach this board over here. It is getting late in the day, but I want to start this process. We're not going to finish it, but we can at least start the process. I think it is helpful, Dr. Burns, at least for me, and I would like you to help me with this --
A Sure.
Q -- to talk about the ways that smokers compensate, okay?
A Yes.
Q Now, you've just been talking about the fact that smokers can compensate by smoking more cigarettes per day?
A That's correct.
Q And, by the way, you have no information that Michelle Schwarz smoked more cigarettes per day when she switched from Benson & Hedges to Merits; is that right?
A I don't have that specific information.
Q You are not aware of it, correct?
A I am aware that there is testimony that she changed her smoking pattern, but not about the

brand of cigarettes.

Q And that gets over to this side of the line, but I want to just make sure. Now, this point, I think you talked about it, but the epidemiological studies didn't sufficiently control, is that the right word, for the number of cigarettes smoked when someone switched from a high tar to a low-tar cigarette?

A No, they did control for that. And they did sufficiently control for it. The problem is you are not then controlling for dose. The reason why cigarettes per day are used is to try and adjust and match up the doses that people get. It is not bad within a single brand of cigarettes.

If you smoke 20 cigarettes a day, you get more than if you smoke 10 cigarettes a day. The problem is, it is not a useful measure of dose if you are now switching from a high-tar brand to a low-tar brand, because you may go from smoking 10 cigarettes a day in a high-tar brand to smoking 20 cigarettes per day in the low-tar brandTherefore, it doesn't measure. You certainly didn't increase your dose. You kept it the same. And, therefore, you don't appropriately control in the epidemiology for the dose of smoking received. And that biases the result in favor of showing a reduction and risk of low-yield cigarettes,

it does not exist in reality.
Q All right. Let's talk about what those studies did take account of accurately. After all, what I understand you are doing with these epidemiological studies is that you are taking a population. In this case, you are taking regular tar smokers and you are trying to compare their disease experience over time with low-tar smokers, right?
A That's correct.
Q Okay. Now, the way that the low-tar smoker is actually smoking the cigarette, let's forget about the numbers and the problems with that for the moment, but the way that he is smoking or she is smoking, and let me see if the list is a good list. And you can change it if you want, taking more puffs. That is a way of compensating within the individual cigarette, right?
A Yes.
Q Taking longer or larger puffs. That is also within the cigarette, right?
A Yes.
Q Inhaling it more deeply. That is a way of compensating within the individual cigarette, not smoking more, right?
A It is actually within the person, but it's

for a cigarette.
Q Holding it in your lungs longer. That is the individual with respect to one cigarette, right?
A That's right.
Q Okay. Puffing more intensely. You mentioned that, right?
A Well, that's taking more and larger puffs.
Q So it's the same issue, maybe saying it a different way?
A Sometimes they talk about drawing faster as making difference and it does, so puffing more intensely is a useful term.
Q So we could maybe put this faster. Would that be better?
A Faster is fine.
Q Okay. Blocking the vent holes with either the lips or the fingers, fingers and the lips, right?
A Right.
Q And smoking it to a shorter butt length. Same cigarette, but you can smoke more of the rod, right?
A That's correct.
Q Okay. Now, I want to go back to these studies because you said these were studies that were performed by preeminent public health scientists,

right?
A Very excellent scientists.
Q Like Dr. Hammond, for example?
A That's right.
Q And these were significant epidemiological studies which gave the public health authorities the information they needed to advise smokers like Michelle Schwarz, right?
A That's correct.
Q Okay. When they did that work, when they looked at low-tar smokers, those studies took account of all the ways in which a smoker compensates. And I'm going to use the words "within the cigarette." I don't want to be confusing you. Because you said sometimes it's what the person does.
But I'm talking about with a individual cigarette now. Is that correct? The epidemiology studies, Dr. Burns, actually, measured the impact of this kind of compensation in terms of whether or not low tar was safer or less a hazardous than a regular tar cigarette?
A Well, unfortunately, that's not correct. And let me explain why. I don't want to take your time, but I can explain why.
Q Go ahead and explain why.

A One of the problems that we face in the epidemiology is you're trying to look at the effect of the difference in high and low-tar cigarettes. That is looked at in two populations who have self selected the product they are going to use. So the people who select those products don't select them randomly. And they may select these low-yield products for a specific reason.

So they may wind up being different. They may be more health conscious, better health behaviors, less intense smokers. The second reason why it is true that you do not control is people who switch. If they are a very intense smoker, if they ingest lots and lots of nicotine from their cigarettes, it may turn out that they smoke 20 cigarettes a day.

But, boy, every cigarette that they smoke, they suck it right down. They take deep puffs. They take deep inhalations. They take lots of puffs out of that cigarette to get the most nicotine they possibly can. That kind of smoker gets a very high dose of tar into their lung.

But if they switch to a very low-yield cigarette, they may find themselves going through four packs of cigarettes a day. They may find that no matter how hard they pull, they can't get enough to

satisfy them out of that cigarette. So they say, "The heck with it. I am going to go back to my old product."

So the very characteristic that you're trying to measure as the type of cigarette is influencing who is in that population. And, therefore, it is not true that within the cigarette, compensation is fully adjusted by taking into account the two populations. They are different because they chose the cigarette that they smoke freely.

And the reasons why they chose it may make them different at the start. And the people who are successful in that transition may differentiate into the high dose smokers staying with the high-tar cigarette, and the low dose smokers migrate.

Q Dr. Burns, what you are telling me, if I understand you correctly, is that, well, maybe the personalities of low-tar smokers are different than high-tar smokers in some ways?

A No, that is not what I am saying.

Q Let me ask you this: Isn't it true, Doctor, that the epidemiological studies, these are the studies that the public health authorities relied upon and did by themselves, and made their recommendations to people like Michelle Schwarz, that

those studies for the past three decades have inherently taken into account the forms of compensation that occur within the cigarette?

A We used to think that that was true. We now understand that it is not.

Q You testified last year in trial that it was true. Has it changed in the last year?

A Yes, it has. We had a much deeper exploration of that topic in the process of formation of that report.

Q And whatever you've concluded in that respect is nothing you've discovered in the last year that has led to a change in the conclusion. It is something that you discovered in Philip Morris' files, right?

A I am not sure what you are saying.

Q Let me ask you this, Doctor. You are familiar with Dr. Jonathan Samet, right?

A Sure am.

Q Dr. Samet is a preeminent epidemiologist, is he not?

A Yes, he is.

Q And in 1996, Dr. Samet said that these epidemiology studies that led the public health authorities to advise Michelle Schwarz to switch to

low-tar cigarettes, which led you to advise Michelle Schwarz to go to low-tar cigarettes, those epidemiology studies took into account compensation within the cigarette. That's what he said, isn't it?

A That's what he said in 1994, that's correct.

Q It was published in 1996, right?

A It was published in 1996, that's correct.

Q And what you are saying now is that having looked at the same data and trying to look at it more carefully, now you don't think that the epidemiology actually even took account of compensation within the cigarette, right?

A I didn't say it didn't take it into account. I said that it didn't fully account for that. That is both my opinion and Dr. Samet's opinion.

Q All right. Maybe we can look at that a little more closely. What you are now saying is that the prior studies, those studies that led you and other public health officials in our government to advise people like Michelle Schwarz to switch to low-tar cigarettes, that those studies did not fully account for all this internal compensation. Is that what you are saying?

A What I'm saying is that the statement that John made, John Samet. The statement John made is that the epidemiology, by nature of controlling for a number of cigarettes smoked per day, adjusts for all of these within cigarette differences.

Q Can I stop you for a second?

A Sure.

Q Make sure I understand that?

A Yeah.

Q What you are saying is that because these studies are actually measuring the disease experience of that smoker, that disease experience is a result of how he or she smoked a cigarette within a cigarette?

A It is as a result of the dose that they got from smoking cigarette.

Q And that dose is a function of how they smoked it?

A It is a function of how they smoked how much they smoked.

Q This is the how much part. You are talking about how they smoked, right? Unless I am missing something, I think you are agreeing with me.

A I am agreeing with you that within the cigarette, the variation and dose is determined by those characteristics. The piece that you are

missing --
Q Can I stop you for a second?
MR. WOBBROCK: Your Honor, Dr. Burns was about to answer the question --
MR. PHILLIPS: You can --
MR. WOBBROCK: Just a second, counsel. Dr. Burns was about to answer the question. Counsel interrupted. I ask that the Court allow Dr. Burns to answer the question.
THE COURT: Dr. Burns is allowed to answer the question.
BY MR. PHILLIPS:
Q I apologize for interrupting you, Dr. Burns.
A It happens all the time. It doesn't bother me much.
The piece that you are missing is that the epidemiology assumed that at the start that these two populations were the same except within the cigarette differences. And what makes the statement that you make that within the cigarette differences are controlled automatically in epidemiology come unstuck is the fact that they aren't the same.
And that measures of dose, how much smoke somebody actually is exposed to, may influence who

chooses the high tar and who chooses the low-tar cigarettes And when that happens, it no longer is true that dose is intrinsically controlled by within the cigarette, by the factors that you have listed there.

Q Just to be clear, what you are saying is not completely controlled; is that fair?

A It is not controlled enough to eliminate the abnormal -- the artificial result that shows a reduction when one doesn't really occur.

MR. PHILLIPS: Just a couple more questions if I can, Your Honor. I realize it is late.

THE COURT: Certainly, counsel.

BY MR. PHILLIPS:

Q Just so that I am clear and the jury is clear on this, at least until the late 1990s, well-meaning public health scientists, people who were concerned about the health of people like Michelle Schwarz, were saying that the epidemiological studies that have been performed for the last 35 years take into account how you smoke a cigarette and still showed a reduction in risk. That is what they were saying, wasn't it?

A That's what they were saying.

Q And the reduction in risk was between 20 and 50 percent when they articulated the results of these epidemiology studies, right?

A I don't believe that most folks in Public Health were using 50 percent. I think most folks in Public Health said that there was a modest risk reduction. It was not proportional to a reduction in time. And that number was usually quoted at least in my experience in Public Health as somewhere around 20 percent, not around 50 percent.

Q All right. So you're saying that most people thought 20 percent. But will you abide the possibility that many scientists with different studies put the range between 20 and 50 percent during that time?

A There are individual studies mathematically that came up with a number that high, that's correct.

Q And you don't consider a 20-percent reduction insignificant, do you?

A No. Had we achieved a 20-percent reduction, we would have had enormous benefit in terms of U.S. lung cancer health. In fact, the observation that that did not happen is what led us to go back and examine this issue in much more detail.

Q Let me ask just ask you this before we break.
MR. PHILLIPS: And this will be my last question, Your Honor.
THE COURT: All right, counsel.
BY MR. PHILLIPS:
Q Just so I am clear and the jury is clear, what led the Public Health community, what led the Surgeon General to its conclusions -- and, by the way, these are conclusions that you regret having made at this point, right?
A I certainly do. They led people down the wrong path.
Q Those conclusions and those recommendations were based on what we've been talking about, the studies of human populations called epidemiology, right?
A They were based on limited data on cigarette design that we had and the data that human populations that we had available, that's correct.
Q Okay. And just to finish up for the day, Philip Morris didn't conduct or effect any of those epidemiology studies, right?
A Not to my knowledge.
MR. PHILLIPS: All right. We'll pick up

tomorrow. Thank you, Your Honor.

THE COURT: Thank you, counsel.

All right, members of the jury, we will break for today. Take your notes to the jury room. Leave them there. Remember not to discuss the case. Be back in the jury room at 8:55. Thank you very much. You are excused.

(The following proceedings were held in open court, out of the presence of the jury:)

THE COURT: All right. Court is out of session. Counsel will be back in at 9 o'clock.

MR. TAUMAN: Your Honor, I don't think it needs to be on the record, but Mr. Dumas knows in the last case there was a lawyer from his office who showed up every day in street clothes and some rather ragged jeans and sat immediately behind plaintiff's counsel table without identifying herself in any way, and there was some interaction.

We don't need to go into the details of that, but it appeared to the plaintiff's counsel she was there for a purpose. This gentlemen right here, whom I don't believe had any similar purpose there, is apparently a lawyer in Mr. Phillip' office. And we would like to avoid any appearance of that situation.

I would like to ask him to identify himself for the record. He has already apologized for any appearance of that, and has agreed to move from behind plaintiff's counsel table.

MR. PHILLIPS: I am not understanding this, Your Honor. There are paralegals and lawyers coming in and out of the courtroom all the time. Some of them are going to be dressed up and some are going to be dressed down. I'll usually be dressed up. Whether it is his business or not, I don't care. I don't think there is any apology that is necessary.

The issue is we are trying the case with witnesses and lawyers at this table. Whether he needs to have people here, I am not going to comment on the fact that Mr. Wobbrock's wife is here or Mr. Tauman's wife has been with us. That has nothing to do with this case.

Frankly, it's beneath the dignity of Mr. Tauman to even raise it. I'm happy to introduce you to this gentleman, Your Honor, who I do know. This is Mr. Rosenthal. He is assisting me, but I think it's irrelevant to either the jury considerations or otherwise. None of us should be playing that game with the jury.

MR. DUMAS: I think there is some sort of suggestion that someone is peering over someone's shoulder and trying to decipher notes, which is the most ludicrous, ridiculous insinuation I've ever heard.

MR. PHILLIPS: Is that the insinuation?

MR. DUMAS: That is exactly the insinuation. Because that was the exact insinuation that plaintiff's counsel, Mr. Gaylord, made in the previous trial. And if the Court would like details on that, I'd be happy to do that off the record in chambers.

Because, frankly, it was one of the most unfortunate displays of lack of professionalism I have seen in this courthouse in 25 years, Your Honor. It had absolutely nothing to do with me or any of the lawyers in my office.

THE COURT: All right.

MR. DUMAS: I know nothing about whatever motivated Mr. Tauman to raise this issue.

THE COURT: All right. Let's don't get into this now.

Here is what the Court would suggest. The attorneys and paralegals who are assisting both sides, the Court would just request that they sit on

the side near those attorneys. Because if someone -- my God, Judge Robinson needs more assistance than anyone else in this courtroom, but if somebody was assisting me, I would want them close by, so I could turn and get that assistance.

I wouldn't want them sitting over there. So consequently if the plaintiff has someone sitting back there to assist them, I wouldn't expect them to be sitting over there near the jury room door behind defense counsel. And if defense counsel has someone assisting them, I wouldn't expect that person to be sitting over here on this side. So just try to keep that in mind.

Sit where they can assist you. And then if anybody wants to draw any conclusions, they can say, "Well, that fine young man sitting back there is helping those guys."

MR. PHILLIPS: We can draw a line down the middle, Your Honor.

MR. DUMAS: They do that in weddings, don't they?

THE COURT: So let's just take care of it that way.

Thank you, counsel. Have a good night. Come back tomorrow and be ready to go at 9 o'clock.

And, Doctor, you may step down.
THE WITNESS: Thank you.
(Court adjourned, Volume 25-C, at 5:05 p.m.)

I, Katie Bradford, Official Reporter of the Circuit Court of the State of Oregon, Fourth Judicial District, certify that I reported in stenotype the oral proceedings had upon the hearing of the above-entitled cause before the HONORABLE ROOSEVELT ROBINSON, Circuit Judge, on February 12, 2002;

That I have subsequently caused my stenotype notes, so taken, to be reduced to computer-aided transcription under my direction; and that the foregoing transcript, Volume 25-C, Pages 1 through 95, both inclusive, constitutes a full, true and accurate record of said proceedings, so reported by me in stenotype as aforesaid.

A transcript without an original signature and red CSR seal is not certified.

Witness my hand and CSR Seal at Portland, Oregon, this 23rd day of August, 2002.

_____

Katie Bradford, CSR 90-0148
Official Court Reporter